STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 00 B. WING	07/16/2013

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F000000	This visit was for a Recertification and State Licensure survey. Survey dates: July 9, 10, 11, 12, 15, and 16, 2013 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N. Census bed type: SNF/NF--161 Total--161 Census payor type: Medicare--9 Medicaid--108 Other--44 Total--161 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on July 23, 2013.	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000247 SS=A	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure a resident was notified regarding a roommate change for 1 of 8 residents interviewed regarding roommate change notification. (Resident #37) Findings include: During an interview on 7/10 /2013 at 1:32 P.M., Resident #37 indicated she had not been notified regarding a roommate change. The record for Resident #37 was reviewed on 7/16/2013 at 2 P.M. Documentation indicating the resident had been notified of roommate change was not found. During an interview on 7/16/2013 at 2:08 P.M., Social Service Director #7 indicated a Care Plan regarding a change in roommates was completed for the person coming to the room, and not the person who was already in the room. 3.1-3(v)(2)	F000247	No Plan of Correction required.	08/14/2013

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to develop a specific Care Plan addressing treatment and services to promote the healing of an open pressure sore of the mid-back spinal area, for 1 resident who was admitted with the open area which healed before discharge, in a sample of 4 residents reviewed for pressure ulcers. (Resident #217) Findings include: On 7/10/13 at 9:45 A.M., two CNAs	F000279	F279 1. Resident #217 was not affected by this deficient practice. The Resident's pressure area of the mid-back spine was completely healed upon discharge to home. Resident had no other skin breakdown during her admission. The wheelchair and cushion utilized by resident during admission belonged to resident and was used in	08/14/2013

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	were observed to transfer Resident #217 into bed following the breakfast meal. The resident had been sitting in a wheelchair in her room, and told the staff her back was "really hurting" her, and she needed to lay down. The resident's bed had a Low Air Loss pressure-relieving mattress. The wheelchair was observed to have a thin pressure-reducing pad on the seat, but no padding on the back. An initial brief review of the clinical record was done on 7/11/13 at 12:43 P.M. An "Admission Nursing Assessment" form, dated 6/26/13 at 2:30 P.M., indicated the resident was admitted that day with a "4 by 4 cm. [centimeters] dark brown area, not open, on coccyx." The form also indicated the resident had a Stage 2 pressure area of the mid-back at the spine, with measurements of 0.5 by 0.5 cm. A "Wound/Skin Healing Record" form, dated 7/4/13, indicated the resident had been admitted on 6/26/13 with a Stage 2 pressure ulcer of the mid-back spine area, and was "healed/scabbed" as of the assessment date of 7/4/13. On 7/12/13 at 9:50 A.M., Resident #217 was observed to be laying in		accordance with resident's preference. It is believed that resident's complaint of pain in her back was due to other clinical conditions not relating to her healed pressure area. 2. As a quality improvement measure, the medical records / skin care documentation of all current and future residents with alteration in skin integrity will be reviewed by Nursing Administration and Wound Nurse. (Record reviews of current residents will be completed by 8/14/13. Record review of future residents will be ongoing). The clinical review of these records will assure that care plans are current and specific for the appropriate interventions of pressure areas. Any deficient practices identified as a result of these record audits will be followed up immediately through disciplinary action, policy development, and / or mandated inservice education. 3. Upon admission, the admitting nurse and Nursing Supervisor, will be responsible for assuring that skin pressure areas are accurately addressed in the resident's care plan. This practice and standard will also assure that any pressure areas	

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	bed, asleep. A transport-type wheelchair was observed parked in the bathroom. There was an "Ergo Seat" pad on seat part of the wheelchair, which was 1 inch thick, with a waffle surface on the under side. There was no padding on the upper back part of the wheelchair. The resident was discharged to her previous living arrangements on 7/12/13, at 10:45 A.M. A further clinical record review was done on 7/15/13 at 10:50 A.M. The resident was admitted on 6/26/13 with diagnoses which included, but were not limited to, end-stage renal disease on hemodialysis, scleroderma (a progressive skin disease), hypothyroidism, and anemia. Physician orders for treatment and an initial Care Plan with interventions for the area on the resident's mid-back spine area were not found. In an interview on 7/16/13 at 10:00 A.M., R.N. #7 indicated she had found Care Plans addressing skin issues. An initial Care Plan entry, dated 6/26/13, addressed a problem of		identified throughout a resident's admission will also be accurately addressed in the resident's care plan. The Unit Manager, Nursing Administration, Nursing Supervisors, and / or MDS Assessment Nurses will be responsible for reviewing admission care plans within 48 hours of admission to assure that all pressure areas are specifically addressed in the care plan. An inservice for licensed nursing personnel will be conducted by 8/14/13 to review this deficient practice and to discuss the plan of correction, care plan audits, ongoing monitoring, etc. 4. Any deficient practice identified as a result of care plan audits by the Unit Manager, Nursing Administration, Nursing Supervisors, and / or MDS Assessment Nurses will be addressed immediately through disciplinary action, policy development, and / or mandated inservice education. Any trends of deficient practice will be reported by Nursing Administration in a written report to the Quality Improvement Committee on a monthly basis. Such monitoring efforts will continue ongoing as a continuous quality improvement measure.	

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	"Alteration in skin integrity as evidenced by:," with no information listed in the following blank space; and "Risk for skin breakdown related to: decreased mobility, debility." The interventions listed were: "Assess area every shift; document progress or lack of progress; Keep skin clean and dry; Provide treatment as ordered by the physician; Keep linens clean and dry; Pressure relieving device(s): Low Air Loss mattress 6/27/13; Encourage 75-100% of food and fluid intake at meals." There were no specific interventions listed for treatment or services related to the area on the resident's mid-back spine area. A subsequent Care Plan, dated 7/5/13, had an entry which addressed a problem of "Resident is at risk for alteration in skin integrity...On admission 0.5 by 0.5 open area spine healed...." Interventions included, but were not limited to, the following: "...4. Administer treatments as ordered; 5. Provide pressure relieving devices to bed and chair; 6. Observe bony prominences for redness; ...8. 7/9/13--ROHO cushion provided; 9. 6/27/13-		5. Date of Completion: 8/14/13	

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	-Low Air Loss mattress." In an interview on 7/16/13 at 10:00 A.M., R.N. #7 indicated there had never been a treatment order for mid-spine area. 3.1-35(b)(1)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to implement treatment and services to promote the healing of an open pressure sore of the mid-back spinal area, for 1 resident who was admitted with the open area that healed before discharge, in a sample of 4 residents reviewed for pressure ulcers. (Resident #217) Findings include: On 7/10/13 at 9:45 A.M., two CNAs were observed to transfer Resident #217 into bed following the breakfast meal. The resident had been sitting in a wheelchair in her room, and told the staff her back was "really hurting" her, and she needed to lay down. The resident's bed had a Low Air Loss pressure-relieving mattress. The wheelchair was observed to have	F000314	F314 1. Resident #217 was not affected by this deficient practice. The Resident's pressure area of the mid-back spine was completely healed upon discharge to home. Resident had no other skin breakdown during her admission. The wheelchair and cushion utilized by resident during admission belonged to resident and was used in accordance with resident's preference. It is believed that resident's complaint of pain in her back was due to other clinical conditions not relating to her healed pressure area. The "Wound / Skin Healing Record" dated 6/26/13 which indicated the Stage 2 pressure	08/14/2013

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	a thin pressure-reducing pad on the seat, but no padding on the back. In an interview on 7/10/13 at 9:50 A.M., Resident #217 indicated she goes to a hemodialysis facility "early in the morning" on Tuesdays, Thursdays, and Saturdays, and "gets Mondays off." She indicated she was in the facility for a short-stay only, and would be going back to her former living arrangements "soon." In an interview on 7/10/13 at 2:20 P.M., R.N. #7 indicated Resident #217 did not have any pressure ulcers. An initial brief review of the clinical record was done on 7/11/13 at 12:43 P.M. An "Admission Nursing Assessment" form, dated 6/26/13 at 2:30 P.M., indicated the resident was admitted that day with a "4 by 4 cm. [centimeters] dark brown area, not open, on coccyx." The form also indicated the resident had a Stage 2 pressure area of the mid-back at the spine, with measurements of 0.5 by 0.5 cm. The 2008 AMDA (American Medical Directors Association) "Pressure Ulcers in the Long-Term Care Setting" Clinical Practice Guideline		wound of the coccyx was a documentation error as the admitting Registered Nurse used the word “coccyx” instead of “mid-spine.” The Unit Manager informed the surveyor of this documentation error during the survey. The resident was placed on a low air loss mattress within 24 hours of admission. The pressure area completely healed, without topical treatment, by 7/4/13, and the resident was discharged to home on 7/12/13 without any additional skin issues. 2. As a Quality Improvement Measure, the skin treatment orders for pressure ulcers of all current and future residents will be reviewed by the Nursing Administration, Unit Managers, Nursing Supervisor, and / or the Wound Nurse. (Record reviews of current residents will be audited by 8/14/13. Record review of future residents will be ongoing and audited within 48 hours of admission). This practice and standard will also assure that any pressure areas identified throughout a resident’s admission will also be accurately addressed with skin treatments / interventions. The clinical review of these records will assure that the treatment orders are current and specific for the appropriate interventions of pressure areas. Any deficient practices identified	

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	manual describes a Stage 2 pressure ulcer as a "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed, without slough." A "Wound/Skin Healing Record" form, dated 6/26/13, indicated the resident had a Stage 2 pressure wound of the coccyx, with measurements of 0.5 by 0.5 cm. There was no assessment for the area on the resident's mid-back. A second "Wound/Skin Healing Record" form, dated 7/4/13, indicated the resident had been admitted on 6/26/13 with a Stage 2 pressure ulcer of the mid-back spine area, and was "healed/scabbed" as of the assessment date of 7/4/13. In an interview on 7/16/13 at 10:58 A.M., R.N. #7 indicated she had called the nurse who had completed the first wound assessment form. That nurse reported that the area of the ulcer was documented in error, and should have been identified as the mid-back spine area. On 7/12/13 at 9:50 A.M., Resident #217 was observed to be laying in bed, asleep. A transport-type wheelchair was observed parked in		as a result of these record audits will be followed up immediately through disciplinary action, policy development, and / or mandated inservice education. 3. Upon admission, the admitting nurse and Nursing Supervisor will be responsible for assuring that treatment orders for pressure areas are accurate and in place, per physician order. This practice and standard will also assure that any pressure areas identified throughout a resident's admission will be accurately addressed with physician ordered treatments. The Unit Manager, Nursing Administration, Nursing Supervisors, and / or MDS Assessment Nurses will be responsible for auditing treatment orders within 48 hours of admission to assure that all pressure areas are appropriately being addressed with physician ordered skin treatments, as necessary. An inservice for licensed nursing personnel will be conducted by 8/14/13 to review this deficient practice and to discuss the plan of correction, care plan audits, ongoing monitoring, etc.	

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	the bathroom. There was an "Ergo Seat" pad on seat part of the wheelchair, which was 1 inch thick, with a waffle surface on the under side. There was no padding on the upper back part of the wheelchair. The resident was discharged to her previous living arrangements on 7/12/13, at 10:45 A.M. A further clinical record review was done on 7/15/13 at 10:50 A.M. The resident was admitted on 6/26/13 with diagnoses which included, but were not limited to, end-stage renal disease on hemodialysis, scleroderma (a progressive skin disease), hypothyroidism, and anemia. The CAA (Care Area Assessment) Summary of the MDS (Minimum Data Set) assessment, dated 7/3/13, indicated the following: "Nutritional Status--85 year old admitted with Diagnoses...Stage I pressure ulcer on mid spinal back. Will order high calorie protein supplement due to weight loss and pressure ulcer. Pressure Ulcer: Resident at risk for alteration in skin integrity due to		4. Any deficient practice identified as a result of skin treatment audits by the Unit Manager, Nursing Administration, Nursing Supervisors, and / or MDS Assessment Nurses will be addressed immediately through disciplinary action, policy development, and / or mandated inservice education. Any trends of deficient practice will be reported by Nursing Administration in a written report to the Quality Improvement Committee on a monthly basis. Such monitoring efforts will continue ongoing as a continuous quality improvement measure. 5. Date of Completion: 8/14/13	

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	decline in ADL's, use of supplemental oxygen via cannula, and recent dysphagia due to scleroderma...." There was no information related to pressure ulcers. Physician orders for treatment and an initial Care Plan with interventions for the area on the resident's mid-back spine area were not found. In an interview on 7/16/13 at 10:00 A.M., R.N. #7 indicated she had found Care Plans addressing skin issues. An initial Care Plan entry, dated 6/26/13, addressed a problem of "Alteration in skin integrity as evidenced by:," with no information listed in the following blank space; and "Risk for skin breakdown related to: decreased mobility, debility." The interventions listed were: "Assess area every shift; document progress or lack of progress; Keep skin clean and dry; Provide treatment as ordered by the physician; Keep linens clean and dry; Pressure relieving device(s): Low Air Loss mattress 6/27/13; Encourage 75-100% of food and fluid intake at meals." There were no specific interventions listed for treatment or services related			

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	to the area on the resident's mid-back spine area. A subsequent Care Plan entry, dated 7/5/13, addressed a problem of "Resident is at risk for alteration in skin integrity...On admission 0.5 by 0.5 open area spine healed...." Interventions included, but were not limited to, the following: "...4. Administer treatments as ordered; 5. Provide pressure relieving devices to bed and chair; 6. Observe bony prominences for redness; ...8. 7/9/13--ROHO cushion provided; 9. 6/27/13--Low Air Loss mattress." In an interview on 7/16/13 at 10:00 A.M., R.N. #7 indicated the facility had placed the Low Air Loss mattress shortly after the resident was admitted. She indicated she had spoken with the Therapy Department, and they had reported they had provided a ROHO (a brand name pressure-relieving seat device) cushion just after admission. The nurse indicated she did not know why the resident would have been in a transport-type wheelchair unless it was her own personal property. The nurse also indicated there had never been a treatment order for mid-spine area, but a barrier cream had been ordered for the coccyx.			

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	3.1-40(a)(2)			

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	155001	A. BUILDING 00 B. WING	07/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to attempt to reduce the dose of an antidepressant medication for 1 of 10 residents reviewed for Unnecessary Medication Use. (Resident #52) Findings include: The record for Resident #52 was reviewed on 7/15/13 at 11:30 A.M. Diagnoses included, but were not limited to, dementia, anxiety,	F000329	F329 1. Upon clinical review of Resident #52, and in consultation with physician, consulting pharmacist, nursing staff, and social worker, it is believed that Resident #52 was not affected by this deficient practice. Even though the physician is not	08/14/2013

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	depression, history of stroke, and breast cancer. The resident was admitted to the facility in March, 2011 from an acute care hospital with a diagnosis of high anxiety. The physician's order recapitulation sheet for July 2013 indicated the resident had been on Cymbalta (an antidepressant medication) 60 mg. (milligrams) daily for anxiety since 3/28/11. A psychologist progress note, dated 3/20/12, indicated the resident was not displaying any anxiety, and there were no behaviors or problems with the resident's mood. The psychologist stopped seeing the resident as of 3/22/12. Physician's progress notes indicated the resident had been on an anti-psychotic medication from 9/18/12. The dosage was decreased on 11/6/12 due to her not having psychosis, or any more episodes of anxiety. Physician's progress notes from 6/29/12 through 7/14/13 indicated the resident had no mood or behavior issues. There was no documentation indicating an attempt for reduction or discontinuation of the Cymbalta 60		currently planning to reduce the Cymbalta, especially while the prescribed administration of Seroquel (antipsychotic) is currently being reduced, the indication for usage will be reviewed by the physician and pharmacist and possibly changed from “Anxiety” to “Depression / Osteoarthritis.” 2. The “indications for usage” of all residents currently prescribed with anti-depressants will be reviewed by nursing staff, social services, physician, and pharmacists during monthly pharmacy audits. Any recommended indications for usage or gradual dose reductions will be presented to the physician for approval. 3. This deficient practice will be discussed during ongoing monthly pharmacy audits, monthly Quality Improvement Committee meetings, monthly behavior meetings with the geriatric psychiatrist, and care plan meetings. Residents identified for possible gradual dose reductions will be presented to the physician for approval. An inservice for licensed nursing	

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	mg. had been considered. In an interview on 7/15/13 at 11:00 A.M., LPN #3 and the Social Services Director (SSD) each indicated they were not aware of the resident having any anxiety. The nurse indicated she was not aware of any attempts for a reduction in Cymbalta. During the interview, the Social Services Director indicated licensed nurses documented behaviors in the clinical record nursing notes for each resident who displayed a behavior. Any staff could use the forms in the orange tracking log book to document observed behaviors or concerns a resident might have, using 1 form for each resident who displayed a behavior. She would then develop a tracking "calendar" from the tracking book for that specific resident and behavior. There was no documentation in nurses notes or any behavior tracking forms found in record indicating the resident had any anxiety or depression symptoms from 6/29/12 through 7/14/13. 3.1-48(b)(2)		and social services personnel will be conducted by 8/14/13 to review this deficient practice and to discuss the plan of correction. This deficient practice will also be discussed with Hooverwood's medical directors and consulting pharmacist by 8/14/13. 4. Any trends of identified residents in need of gradual dose reduction will be presented by the consulting pharmacist on a quarterly basis during the quality improvement committee meetings. Continued identification of residents lacking attempts of gradual dose reduction will be carefully addressed by the Medical Director. 5. Date of Completion: 8/14/13	

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to maintain clean equipment, and failed to follow correct procedures for use of hairnets and disposable gloves to prevent cross-contamination of food, for 1 of 1 facility kitchen. This deficient practice had the potential to affect 161 of 161 residents residing in the facility. Findings include: 1. The kitchen observation tour was completed on 7/9/13 at 10:04 A.M., with the Dietician/Food Service Director and the Food Service Manager in attendance. The following was observed: A. A fan with dark particulate matter on the blades was blowing into area where clean silverware was exposed. In an interview at that time, the Dietician indicated this was an area where dietary staff dished up food.	F000371	F371 1. No residents were found to have been affected by these deficient practices due to no reports or complaints of illness identified during this time. 2. Due to the correction actions immediately taken as a result of these deficient practices, there were no other residents identified with the potential of being affected by this same deficient practice. The correction actions immediately taken were as follows: The fan was thoroughly cleaned and removed from the kitchen area. The plate warmer was thoroughly cleaned. **{see**	08/14/2013

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	B. A plate warmer was observed to have visible dried food spillage on it. C. The steam table had a large amount of dried food matter on the bottom section and around the steam table legs. In an interview on 7/9/13 at 10:25 A.M., the Dietician indicated these areas were to be cleaned weekly. On 7/9/13 at 12:05 P.M., an unidentified non-dietary employee was observed walking into the kitchen, and past the steam table where food was ready to be served. The employee did not have a hair net on. On 7/9/13 at 12:20 P.M., an unidentified dietary aide was observed with long braids hanging out of her hair net while going in and out of the kitchen. She walked by the steam table, from which the prepared food was to be served, and back out into the resident dining area to serve residents their food. The same unidentified dietary aide was observed to go into the kitchen, and with gloved hands, touch the refrigerator handle to open the		**attachment #1}** The steam table was discarded and replacement is on order. All frozen food items were immediately removed from the freezer and placed in the walk-in freezer. The freezer was discarded and replacement is on order. **{see attachment #2, pg1-4}** The non-dietary employee without a hair net received disciplinary action**.** This employee's department / co-workers participated in an inservice regarding this deficient practice. **{see attachment #3, pg 1-2}** The dietary employee received disciplinary action regarding the use of hair net and gloves. Another dietary employee received disciplinary action regarding the freezer temperature logs. **{see attachment #4, pg 1-2}** **3.** The Food Service Director had a meeting with the dietary employees to review these deficient practices. Cleaning assignments, temperature logs,	

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	refrigerator to get a can of soda pop for a resident. Without changing the gloves or washing her hands, the aide proceeded to go back into dining room and give the can of pop to the resident. Without changing the gloves or washing her hands, the aide was observed to hold tongs in one hand and a salad bowl in the other. She used the tongs to scoop up some salad and place in the bowl. While doing so, she touched the raw salad with her gloved hands. In an interview on 7/16/13 at 11:25 A.M., the Dietician indicated he expected employees to remove their gloves and wash their hands before dishing up salad. He also indicated if employees were around the food prep area, or where there would be exposure to the food, they should have a hair net on with the hair contained and secured. On 7/16/13 at 11:35 A.M., the Dietician provided an undated policy/procedure titled "Dietary Food Handling Policy." The policy indicated, "...1. The kitchen and equipment are clean... Hairnets and gloves are to be worn when serving meals on the serving line or in the main dining room when serving residents. Ensure gloves do not		use of hair net, use of gloves, food handling, etc., were all carefully reviewed by the Food Service Director. **{see attachment #5 pg, 1-2}** A posting, regarding the required use of a hairnet and a supply of hairnets, has been placed at every entrance to the kitchen. **{see attachment #6 pg, 1-2}** These deficient practices will be closely monitored by the Food Service Director, Food Service Manager, and the Chefs. In addition, the Executive Director, Chief Financial Officer, and / or the Infection Prevention Nurse will be conducing unannounced, bi-weekly sanitation rounds for three months. Following these bi-weekly rounds, monthly rounds will be completed on an ongoing basis. The results of the monthly rounds will be reported at the monthly Quality Improvement committee meetings. Further observations of deficient practices involving sanitation, temperature readings, food handling, use of hairnet and gloves, etc., will be addressed immediately with disciplinary action, policy development, and	

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	come into contact with non-food surfaces(i.e. tables clothing etc.). Change gloves as necessary and follow department hand-washing policy...." Completed cleaning logs for April through June, 2013 were provided by the Dietician on 7/10/13 at 1 P.M. A cleaning log for July was not included in the information provided. The log for June 2013 indicated, "...Delime all steamers and hot wells...." There was nothing on the list addressing the cleaning of the plate warmer. 2. The kitchen observation tour was completed on 7/9/13 at 10:04 A.M., with the Dietician/Food Service Director and the Food Service Manager in attendance. At 10:14 A.M., the thermometer inside of the bakery freezer indicated the temperature was currently 22 degrees Fahrenheit. Frozen cookies were soft to the touch. The other items in the freezer were slightly thawed. No potentially hazardous food was observed. In an interview on 7/9/13 at 10:15 A.M., the Dietician indicated he expected the temperature of the bakery freezer to be 0 (zero) degrees		mandated inservice training. 4. Any observation of deficient practices will be communicated in a written report at the monthly Quality Improvement committee meetings by the Food Service Director, Executive Director, Chief Financial Officer and / or the Infection Prevention Nurse. Trends of re-occurring deficient practices will lead toward disciplinary action, policy development, and mandated inservice training. 5. Date of Completion: 8/14/13	

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	Fahrenheit. The July, 2013 bakery freezer temperature logs were provided by the Dietician on 7/10/13. The freezer temperature for the first 8 days of July were documented as ranging from 20-24 degrees Fahrenheit. The freezer temperature logs for the month of June also indicated temperatures ranging from 20 to 24 degrees Fahrenheit. A dietary policy, dated 1/2012, was provided by the Dietician on 7/10/13 at 1:00 P.M. The policy indicated "...Each refrigerator and freezer contains a thermometer accurate to 3 degrees Fahrenheit and is easily read. The refrigeration is checked daily in the AM and PM and recorded on the proper form. If the temperature recorded is not within range, report the discrepancy to the supervisor immediately. If the temperature is not appropriate since the last reading was taken, food, especially perishables may need to be discarded...." 3.1-19(bb) 3.1-21(i)(3)			

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F000456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview and record review, the facility failed to maintain 1 of 3 freezers within proper temperature range, in 1 of 1 facility kitchen. This deficit practice had the potential to impact 161 of 161 residents receiving food from the kitchen. Findings include: The kitchen observation tour was completed on 7/9/13 at 10:04 A.M., with the Dietician/Food Service Director and the Food Service Manager in attendance. At 10:14 A.M., the thermometer inside of the bakery freezer indicated the temperature was currently 22 degrees Fahrenheit. Frozen cookies were soft to the touch. The other items in the freezer were slightly thawed. No potentially hazardous food was observed. In an interview on 7/9/13 at 10:15 A.M., the Dietician indicated he expected the temperature of the bakery freezer to be 0 (zero) degrees	F000456	F456 1. No residents were found to have been affected by this deficient practice due to no reports or complaints of illness identified during this time. During the observation of this deficient practice, there were no potentially hazardous foods observed. Nevertheless, all of the frozen foods in this freezer were immediately removed and stored in the kitchen's walk-in freezer. 2. Due to the fact that no potentially hazardous foods were observed in the freezer, and these items were immediately removed and stored in another freezer, no other residents had the potential of being affected by this same deficient practice. Furthermore, this freezer was discarded and a replacement freezer is on order. 3. Upon the delivery and installation of the new freezer,	08/14/2013

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	Fahrenheit. The July, 2013 bakery freezer temperature logs were provided by the Dietician on 7/10/13. The freezer temperature for the first 8 days of July were documented as ranging from 20-24 degrees Fahrenheit. The freezer temperature logs for the month of June also indicated temperatures ranging from 20 to 24 degrees Fahrenheit. A dietary policy, dated 1/2012, was provided by the Dietician on 7/10/13 at 1:00 P.M. The policy indicated "... Each refrigerator and freezer contains a thermometer accurate to 3 degrees Fahrenheit and is easily read. The refrigeration is checked daily in the AM and PM and recorded on the proper form. If the temperature recorded is not within range, report the discrepancy to the supervisor immediately. If the temperature is not appropriate since the last reading was taken, food, especially perishables may need to be discarded...." 3.1-19(bb)		temperature logs will continue to be closely monitored in accordance with departmental policy. Any temperature readings that are deficient will be immediately reported to the Maintenance Department for immediate follow-up. If the Maintenance staff is not able to address / repair this issue, the food from the freezer will be stored in another freezer until the time that the temperature problem is resolved. 4. On a daily basis, the Food Service Director, Food Service Manager and Chefs will be monitoring the temperature logs. On an unannounced, bi-weekly basis for three months, and monthly thereafter, the Executive Director, Chief Financial Officer, and / or the Infection Prevention Nurse will be checking these temperature logs during kitchen sanitation rounds. Any deficient practices will be addressed immediately with necessary repair, disciplinary action, policy development, and / or mandated inservice education. On a monthly basis, the Food Service Director will be presenting a written report to the Quality Improvement committee regarding freezer temperatures, repairs, etc.	

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F000465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain resident room entry doors in a good condition, for 11 resident rooms on 2 of 5 units, and on 1 of 2 floors. (Room numbers A 201, 208, and 213; Room numbers B 219, 216, 217, 212, 210, 208, 204, and 222) Findings include: On 7/9/13 at 12:52 P.M., some resident room entry way doors were observed to be marred and/or had multiple scrapes and tears of the laminate covering. On 7/10/13, from 11:18 A.M. to 11:27 AM, a further observation was conducted. Resident room doors consisted of a regular width entry door, with a narrower adjoining door, which could be opened to allow a wider access to the room. The resident room entry doors were observed to have noticeable mars, dings, tears in the laminate covering, chucks of laminate missing, large and long scrapes, and/or torn foam	F000465	F465 1. Residents residing in rooms 2A: 201, 213, 208 and rooms 2B: 219, 216, 217, 212, 210, 208, 204, and 222 were not found to have been affected by this deficient practice. No reports or complaints from residents and / or family members were identified. No injuries or ill effects have been identified as a result of this deficient practice. All damaged doors, were immediately repaired by the Maintenance Director and staff.**{see attachment #7, pg 1-2}** 2. Every resident room door in the building will be inspected and repaired by the Maintenance Department by 8/14/13. As a result of this quality improvement measure, no other residents will have the potential of being affected by this same deficient practice.	08/14/2013

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	stripping on the narrower door where the two doors met when closed. The damage was observed at various places on the lower half of the doors and at the outside corners for the following rooms: A. Second floor, 2 A unit: Rooms 201 and 213. On 7/15/13 at 9:30 A.M., an additional room, Room 208, was observed to have a large chunk of laminate out at the bottom corner of the the small door, with torn foam stripping. B. Second floor, 2 B unit: Rooms 219, 216, 217, 212, 210, 208, 204, and 222. In an interview on 7/15/13 at 10:05 A.M., the Director of Environmental Services indicated there were no current remodeling or major repair programs started, on-going, or planned at this time. He indicated a major resident room remodeling project, perhaps at least 5 years in the future, was planned. The flooring in each resident room was especially targeted for upgrade. In an interview on 7/15/13 at 10:25 A.M., the Director of Environmental Services indicated a Maintenance Communication Log book was		3. Maintenance logs will continue to be maintained on all five nursing units. Staff will be encouraged to document any further door damages in the maintenance logs. These logs are checked 6 days per week and all repairs are done as quickly as possible. On a monthly basis, the Maintenance Director, Director and Assistant Director of Environmental Services, and / or the Executive Director will conduct maintenance rounds in order to identify and further deficient practices. Any deficient practices will be documented and followed up with repair, replacement, disciplinary action, policy development, and / or mandated inservice education. 4. Deficient practices, identified from monthly environmental rounds, will be reported in writing to the Quality Improvement committee on a monthly basis for review. Trends in deficient practices may lead toward further repair, replacement, training, and / or disciplinary action. 5. Date of Completion: 8/14/13	

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	located on each unit for staff to record any issues that the Housekeeping/Laundry/Maintenance departments needed to address. Immediate or emergency issues were called to the Maintenance Department. He indicated that questions about the doors was a "Maintenance Director question;" and that he would have to talk with the Maintenance Director to determine if any requests had been made for repairs to resident room doors. He indicated the facility had the ability and equipment to re-laminate doors that had been damaged. He believed the Maintenance Director had a preventative maintenance program, but was not sure if checking resident room doors on a regular basis was on the list. In an interview on 7/15/13 at 10:45 A.M., the Maintenance Supervisor indicated he checked the resident room doors about every 1-2 months. He indicated he was able to re-laminate, fill gouges, sand the areas down, re-paint, or repair the damage as necessary. He indicated the staff did not generally notify Maintenance about damaged doors, he just had to check them. He indicated he had tried using a plastic guard on the lower portion of the			

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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	doors at one time, but the panel didn't work all that well in protecting the doors from damage. 3.1-19(f)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to accurately document the skin condition and clarify conflicting information about a Stage 3 pressure ulcer which was either present on, or developed after, admission, for 1 of 4 residents reviewed for pressure ulcers. (Resident #24) Findings include: The closed clinical record for Resident #24 was reviewed on 7/12/13 at 2:43 P.M. The resident was admitted on 3/20/13 with diagnoses which included, but were not limited to, Stage 4 colorectal cancer with metastases to the liver, loop sigmoid colostomy surgery, chronic kidney disease with renal	F000514	F514 1. Resident #24 expired on 4/10/13 due to the progression of end-stage rectal cancer. Her pressure ulcer was present upon admission. The resident was placed on a low air loss mattress upon admission and received skin care interventions per physician orders beginning 3/28/13. The resident never exhibited any pain or discomfort originating from this pressure ulcer. Per clinical review, this pressure ulcer did not worsen from the time it was identified until the time of her death. As a result, it is believed that this resident was not found to have been affected by this deficient practice.	08/14/2013

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	failure, ureteral obstruction, hypertension, and diabetes. The resident expired on 4/10/13. A facility "Pre-Admission Assessment" form, dated 3/19/13, indicated the resident had bilateral sacral spine pressure ulcers, "unable to visualize, dressing: mepliex foam." An "Admission Nursing Evaluation" form, dated 3/20/13 at 2:00 P.M., indicated the resident had a scar on the abdomen and a colostomy. No pressure sores were identified or documented on the form. A "Clinical Summary," dated 3/25/13 and completed by a facility Assistant Director of Nursing, indicated "... Admitted to facility with an open area on her sacral spine, with significant risk for further skin breakdown. Placed on LAL [Low Air Loss] mattress on day of admission, ordered house supplement...." A "Wound/Skin Healing Record" form, dated 3/27/13, indicated the onset date of a Stage 3 coccyx pressure ulcer was 3/27/13, and measured 1 X 2 X .2 cm. (centimeters). The MDS (Minimum Data Set) assessment was completed on		2. As a quality improvement measure, the medical records / skin care documentation of pressure areas of all current and future residents with pressure ulcers will be reviewed by the Nursing Administration and Wound Nurse. (Record reviews of current residents will be completed by 8/14/13. Record review of future residents will be ongoing). The clinical review of these records will assure that pre-admission documentation is being used to alert nursing staff to potential skin issues and that the nursing admission assessment accurately captures the resident's current skin issues upon admission. The MDS Nurse and the Nurse authoring the 450-B will assure that their documentation is consistent with the admission assessment. Any deficient practices identified as a result of these record audits will be followed up immediately through disciplinary action, policy development, and / or mandated inservice education. 3. Upon admission, the admitting nurse and Nursing Supervisor will be responsible for assuring that skin pressure areas are accurately identified and treatments are ordered and followed per physician order.	

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	4/2/13. Section M, for Skin Conditions, indicated the resident had one or more unhealed pressure ulcers at Stage 1 or higher, that the current unhealed pressure ulcer was a Stage 3, and that the pressure ulcer was present on admission. The accompanying CAA (Care Area Assessment) Summary, indicated "Resident was admitted with a Stage III area to her sacrum on admission...." On 7/15/13 at 3:30 P.M., the Director of Nursing was given the opportunity to submit any documentation that clarified when the resident's pressure ulcer developed. On 7/16/13 at 11:20 A.M., the Director of Nursing provided a paper summarizing an earlier interview about the documentation. She indicated the "Preadmission Assessment" form was completed by facility admission staff using acute care hospital information. A copy of that information, dated 3/18/13, indicated "Pressure Ulcer: bilateral sacral spine; unable to visualize; dressing: Mepliex foam." The "Clinical Summary" information was completed using the preadmission information. The		This practice and standard will also assure that any pressure areas identified throughout a resident's admission will also be accurately addressed with assessment and treatment. The Unit Manager, Nursing Administration, Nursing Supervisors, and / or MDS Assessment Nurses will be responsible for reviewing wound documentation and admission assessments within 48 hours of admission to assure that all pressure areas are addressed in the care plan. An inservice for licensed nursing personnel will be conducted by 8/14/13 to review this deficient practice and to discuss the plan of correction, documentation audits, ongoing monitoring, etc. 4. Any deficient practice identified as a result of skin documentation audits by the Unit Manager, Nursing Administration, Nursing Supervisors, and MDS Assessment Nurses will be addressed immediately through disciplinary action, policy development, and / or mandated inservice education. Any trends of deficient practice will be reported by Nursing Administration in a written report to the Quality Improvement	

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	nursing staff member who completed the summary had not visually evaluated the resident's skin. The MDS nurse competing the CAA on 3/27/13 took her information from the preadmission assessment paperwork and from the nurse reporting the pressure sore on 3/27/13. The MDS nurse had not previously visually assessed the resident's skin. In the interview, the Director of Nursing indicated the hospital "Discharge and Transfer" form did not identify a pressure ulcer, and that the facility physician did not address a pressure ulcer in her admission note dated 3/21/13. The Director of Nursing indicated she had contacted the facility admitting nurse, who reported she was positive she would have addressed an open area (on the admission form) if one was present, just as she had addressed the abdominal scar and colostomy. The Director of Nursing indicated she had reviewed all of the shift reports from 3/20/13 through 3/28/13, and the first reporting of the area was on 3/27/13. 3.1-50(a)(2)		Committee on a monthly basis. Such monitoring efforts will continue ongoing as a continuous quality improvement measure. 5. Date of Completion: 8/14/13	

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